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Train GPs to provide good sexual health care

Congratulations on the *BJGP* editorial in the July issue!¹ Anything that raises awareness among GPs of the need for targeted opportunistic chlamydia screening can only be a good thing.

I am a British vocationally trained GP and I became interested in sexual health (that is, genitourinary medicine [GUM]) when I did a term at Mortimer Market Centre GUM clinic in London during my GP training. Due to a fundamental difference in training in Australia and the UK, I moved to Sydney to train in sexual health after finishing GP vocational training and working as a locum.

To give them their credit, the Australian authorities have always recognised the key role that GPs have to play in the sexual health of the nation, and have encouraged them to both train in sexual health and deliver it on a daily basis to their patients in their own surgeries. Hence, GPs here are encouraged to diagnose, treat, and follow up sexually transmitted infections (STIs). Contact tracing here is the responsibility of the doctor who ordered the test. Obviously complex cases will be referred to the sexual health clinics, but many cases could be resolved within primary care.

There are several local and national bodies running training courses and programmes tailored to the specific needs of GPs. I have been training with the Australian Chapter of Sexual Health Medicine since 2001, and they have had no problem accepting my GP background and qualifications. Contrast that with the approach of the UK Royal College of Physicians (RCP) regarding higher training in GUM — you must have the MRCP or MRCOG to start. Once I complete my training I will be dually qualified.

The UK does have something to learn

from the Australian model. Encouraging and empowering GPs to deliver sexual health care is the way to go. Any GP should be able to manage an uncomplicated case of gonorrhoea or chlamydia. GPs in Australia often manage syphilis, and there is a specific group of GPs in Sydney and Melbourne who provide holistic care for HIV-positive patients, including antiretroviral prescribing in all its complexity.

My point is that, as your editorial points out, in the UK 'the whole sexual health service seems to be a shambles'.² This is due to a mixture of: underfunding and under-resourcing; neglect; lack of planning; mushrooming bureaucracy; indifference from those in senior management in the health service at national and local/trust level; failure to make reliable, more efficient, patient-friendly new technology testing methods more widely available and used; and a large increase in the number of patients seeking to attend GUM clinics, be it because of increased awareness, increased testing in the community, or increased incidence of bacterial STIs. If UK GPs were encouraged and given the opportunity to attend appropriate training, and then supported at a local and national level, more patients with sexual health problems would have these attended to in the community, hence taking off some of the pressure on GUM clinics.

Having worked as a GP in the UK, I believe that GPs have the skills and the ability to manage many patients with sexual health problems in primary care, if given the appropriate training and support. This training should not only involve the existing DRCOG, DFFP and DipGUM; there should be specific GP-tailored government and health service sponsored courses, programmes, clinical attachments and so forth if substantial progress is to be made in the care of the nation's sexual health.

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References

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Fast-track cancer diagnoses

The results of Cornford *et al*'s¹ qualitative study effectively highlighted the stark contrast in priorities between patients wanting an urgent appointment to reassure them that they don't have cancer, and the specialists who wish to diagnose as high a proportion of cancer cases as possible. With a commitment to the patient's biopsychosocial wellbeing we are as GPs, once again, somewhere in the middle.

We initially wondered if patient recruitment was biased by self-selection. Those who responded may have been the most anxious, harbouring the strongest feelings about a timely diagnosis, hence effectively being an unrepresentative sample. This observation however, leads to a new hypothesis.

Are those patients who are found to not have cancer on the 2-week wait system, on the whole, better educated, more health motivated, more aware of their rights, more empowered in the GP consultation setting, and more anxious? If this is the case, then have we unwittingly created a two-tier system in which, apart from cases with obvious cancers, we are facilitating a service that reassures the worried well at the expense of all cases that are presenting outside the 2-week wait criteria,² and whose outcomes may be adversely affected by a longer wait.